Chart #_____

South Dakota Family Planning
Department of Health

SOUTH DAKOTA DEPARTMENT OF HEALTH
HEALTH AND MEDICAL SERVICES
FAMILY PLANNING PROGRAM

REQUEST FOR AN INTRAUTERINE DEVICE (IUD) BY WOMEN WITH HIGH RISK FACTORS

IUDs, like any method of birth control, are not always suitable for all women. Risks versus benefits are determined for each woman.

Your medical history and examination show you may be at risk if you use an IUD. Initialed below are symptoms or conditions which might lead to serious side effects if you use an IUD.

_____ Complications of IUD use that may affect your desire for future fertility
_____ History of any pelvic infection
_____ Acute or chronic cervicitis and/or vaginitis
_____ History of ectopic pregnancy
_____ Valvular heart disease or rheumatic heart disease
_____ History of gonorrhea, Chlamydia, or mucopurulent cervicitis
_____ Exposure to multiple sexual partners.
_____ Partner who has multiple sexual partners
_____ Recent abortion or term pregnancy (in last 4 weeks)
_____ Nulliparous – never having been pregnant
_____ Severe uterine anteflexion or retroflexion
_____ Hemoglobin of 9 gm to 11.5 gm
_____ Moderate or severe dysmenorrhea
_____ Menorrhagia or metrorrhagia
_____ Previous IUD tolerance, expulsion or failure
_____ Inability to check for the IUD string
_____ History of surgery that may be associated with ectopic pregnancy

The above side effects, symptoms, and conditions have been explained to me. I read the instruction sheet, the manufacturer's booklet, and I desire to have the IUD prescribed. Once the IUD is inserted, I will return to the clinic following my first menstrual cycle or within 3 months for a follow-up exam.

I have been advised of and accept the possible serious risk and harm that may result from my using an IUD. The health care provider has explained my condition in a satisfactory manner. The health care professional answered all my questions. I may ask any questions at any time. I may seek an alternate method of birth control at any time.

I release the South Dakota Department of Health, South Dakota Family Planning Program, its employees or agents from any and all claims, damages, or liabilities which I may have against them as a result of the receipt of medical services, supplies and/or procedures.

_____ _____
Client Signature Date

_____ _____
Witness Signature Date